FOR ARGUMENT

Nos. 02-1845 and 03-83

Supreme Court, U.S.
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In The
Supreme Court of the United States

AETNA HEALTH INC., FKA AETNA U.S. HEALTHCARE INC. AND AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION,

Petitioner,

v.

RUBY R. CALAD, ET AL.,

Respondent.

On Writs Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF FOR *AMICUS CURIAE* SENATORS EDWARD M. KENNEDY, JOHN McCAIN, BOB GRAHAM AND REPRESENTATIVES JOHN D. DINGELL, CHARLIE NORWOOD, GEORGE MILLER, AND CHARLES B. RANGEL IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether ERISA is intended to preempt malpractice jurisprudence, provided by state law when an HMO entity, acting through one or more of those in its employ or on its behalf, denies a request for care and treatment as not medically necessary where the denial results from medical decision-making based upon the exercise of discretionary judgment.

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INTEREST OF *AMICI CURIAE*[1]

Amici United States Senators and Representatives are primarily members of Congress who were serving in Congress at the time of the adoption of the Employee Retirement Income Security Act (hereinafter "ERISA" or "the Act") and the Health Maintenance Organization Act (hereinafter "HMO Act"), serve on committees of jurisdiction over ERISA or health care, and/or have sponsored Patients' Bill of Rights legislation to provide a federal and state system of guaranteed rights and responsibilities to the over 200 million American workers and their families who are covered by ERISA health plans or other health insurance.

Amici have a strong interest in providing the Court with information regarding Congress' intent at the time of enactment of ERISA and thereafter. Recent legislative debate over enactment of a federal Patients' Bill of Rights was expressly focused on the issue of meaningful causes of action and redress under ERISA as well as traditional state jurisdiction over health care and torts. Although Congress has yet to enact a federal Patients' Bill of Rights, an overwhelming majority of the members of Congress, on a bipartisan basis, have supported the principle that state standards which bring into focus accountability by those

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[1] Petitioners and Respondents have consented to the filing of this brief in letters filed with the clerk. No counsel for a party authored this brief in whole or in part. Members of Congress made a monetary contribution to the printing of this brief.

whose judgments decide what is medically necessary care and treatment on an on-going basis must not be altered by federal law. *Amici* also do not believe that ERISA intended to displace state malpractice laws, and do not believe such laws conflict with the purposes or structure of ERISA.

SUMMARY OF THE ARGUMENT

During legislative development and consideration of ERISA, Congress was predominantly focused on establishing minimum standards to protect the pension promises made to millions of workers and their families. Congress did not intend for ERISA's pension standards to be interpreted by the courts as preempting state health care laws. Congress intended to regulate health care through legislation other than ERISA. Although ERISA was amended in conference to expand its provision on preemption of state laws, Congress had no intention of preempting a wide swath of state laws such as state health care laws or malpractice laws. There is no legislative history in ERISA, the HMO Act, or any other laws that indicate that Congress intended to preempt state health care regulation or malpractice laws. During recent consideration of legislation to enact a Patients' Bill of Rights, a bipartisan majority of Congress has indicated its intention to establish minimum health insurance patient protection standards apart from ERISA and to make clear that insurers and health maintenance organizations should be accountable for their discretionary medical decisions, including mixed eligibility and treatment decisions, under state law. Such

legislative efforts are not the result of any need to reform what was primarily a pension bill – but are the result of an accumulation of court decisions which have incorrectly construed ERISA as providing a shield for medical decision-makers.

ARGUMENT

I.

ERISA WAS ENACTED TO PROTECT PARTICIPANTS AND BENEFICIARIES ELIGIBLE UNDER EMPLOYEE BENEFIT PLANS

At its core, ERISA was designed to provide basic minimum rights to workers regarding their pension plans. The Act was the result of almost 10 years of legislative consideration by the Congress. The impetus for the bill was a series of bankruptcies by a number of employers. Under these bankruptcies, tens of thousands of older workers lost their jobs and could not retire with their pensions. While their employers had promised pensions to these workers, they had failed to fund the pension plans. In light of this crisis, the debate in Congress focused on developing a system for requiring employers to vest long-service employees with promised benefits and fund pension plans over a reasonable period of time. The debate was an urgent one. At the time, of the tens of thousands of pension plans then in existence, fewer than 20% were funded. *See* 120 Cong. Rec. 29,933 *et seq.* (1974) (statement of Sen. Javits (R-NY)).

On September 2, 1974, thirty years ago this year, Congress enacted ERISA. The Congressional Findings and

Declaration of Policy of the Act lay out the legislation's purposes and goals:

> The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial, that the operational scope and economic impact of such plans is increasingly interstate, that the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . and it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that *minimum standards be provided assuring the equitable character of such plans and their financial soundness.*

29 U.S.C. § 1001(a) (2003) (emphasis added). What Congress meant by these "minimum standards" becomes clear with an examination of the Act's legislative history.

The legislative history demonstrates a clear congressional intent for ERISA to provide basic rights to working men and women as pension plan participants and beneficiaries. Congress' focus was on creating minimum standards by which the pension plan promises of employers would be measured and enforced. During House floor debate on ERISA, Rep. Perkins (D-KY), a lead cosponsor of the bill, explained the legislation's purpose: "We have *basic minimum pension rights* written into this bill which should have been enacted many, many years ago *to protect the rights of working people*." 120 Cong. Rec. 29,192 (1974) (statement of Rep. Perkins) (emphasis added). The Senate debate contains similar statements. Senator Williams (D-NJ), one of the bill sponsors, opened his floor statement by stating, ". . . I am happy to report that after long and

numerous meetings of the conferees of HR 2, we are able to bring before the Senate a conference agreement which has been unanimously adopted, and which, for the first time, *will safeguard the pension expectations of American workers*." 120 Cong. Rec. 29,928 (1974) (statement of Sen. Williams) (emphasis added). Senator Javits, the lead sponsor of the Senate bill, highlighted that the bill ". . . represents *a series of fundamental guarantees* made to every American worker – guarantees that will secure for millions of Americans the expectation of a decent retirement income in combination with social security. These guarantees are *nothing less than a pension 'bill of rights'* to which every worker – regardless of his occupation, salary or status – is entitled." 120 Cong. Rec. 29,933 (1974) (statement of Sen. Javits) (emphasis added).

In enacting ERISA, Congress believed it was providing a series of federal pension rights to workers and their families. Its focus was entirely on establishing new minimum protections, not eliminating a wide swath of long-standing traditional state protections.

II.

ERISA CONTAINS A COMPREHENSIVE SCHEME OF RIGHTS AND RESPONSIBILITIES FOR PENSION PLANS, BUT NOT FOR HEALTH PLANS AND OTHER TYPES OF EMPLOYEE BENEFITS.

As the Court has noted in several of its decisions, ERISA contains a comprehensive system of rights and responsibilities for certain types of employee benefit plans – namely, pension plans. *See, e.g., Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d 39 (1987); *New York State Conference of Blue Cross & Blue*

Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed. 2d 695 (1995). ERISA does not provide such a comprehensive scheme for health plans and other types of non-pension employee benefits.

In fact, its very title reveals its focus on retirement and pensions. This pension focus was no accident. At the time of enactment, adoption of a national health care system appeared imminent. President Nixon had proposed a national mandated employer-based system, and leading Democrats supported a national government system. *See* S. 1422, 93rd Cong., 1st Sess. (1973) (introduced by Sen. Kennedy (D-MA)); H.R. 1 and H.R. 33, 93rd Cong., 1st Sess. (1973) (introduced by Reps. Ullman (D-OR) and Dingell (D-MI), respectively). In other words, while ERISA presented a comprehensive scheme for regulating pension plans, Congress had other efforts in mind for grappling with the provision of health care – efforts which continue to this day.

The pension focus is evident throughout the Act. The main title of ERISA, Title I, contains the following five parts: 1) reporting and disclosure, 2) participation and vesting, 3) funding, 4) fiduciary responsibility, and 5) administration and enforcement. 29 U.S.C. § 1001 *et seq.* (2003). Each of these parts provides detailed rules to which pension plans must comply. Pension plans must annually file detailed financial disclosure forms with the Internal Revenue Service. 29 U.S.C. §§ 1021-1031 (2003). Pension plans must provide coverage to specific categories of employees, vest their right to benefits after a specific period of time, accrue benefits in specific form, and pay benefits at specific times. 29 U.S.C. §§ 1051-1061 (2003). Pension plans must comply with detailed rules for funding. 29 U.S.C. §§ 1081-1086 (2003). Employers must

adhere to a strict scheme of fiduciary responsibility for the management of all pension fund monies. 29 U.S.C. §§ 1101-1114 (2003). And participants, beneficiaries, employers, plans and the Secretary of Labor have elaborated rights and responsibilities to achieve compliance with the Act. 29 U.S.C. §§ 1131-1147 (2003).

In contrast to this extensive regulatory scheme for pension plans, non-pension benefit plans are only subject to three of the five parts of ERISA Title I – reporting and disclosure, fiduciary responsibility, and administration and enforcement – and even then in abbreviated form. For instance, welfare plans such as health insurance are subject only to simplified reporting requirements, if any. In a provision which plainly underscores Congress' pension focus, the Act leaves it to the Secretary of Labor to either exempt welfare benefit plans entirely from the reporting and disclosure requirements of Title I or create simplified reporting regulations for these non-pension plans. 29 U.S.C. § 1024(a)(3) (2003). And as the Court has noted, aspects of the fiduciary responsibility rules also may be construed as inapplicable since the primary functions of non-pension plan fiduciaries do not involve discretionary authority or control respecting management of the plan or its assets. *Pegram v. Herdrich*, 530 U.S. 211, 231-232, 120 S.Ct. 2143, 2155-2156, 147 L.Ed. 2d 164, 182-183 (2000); *see also* 29 U.S.C. § 1002(21) (2003) (ERISA's definition of a fiduciary).

Even ERISA's causes of action primarily make sense in the context of pension benefits. In a pension plan, an employer promises to provide a retirement benefit to certain employees upon reaching a specific age or termination of employment and based on a predetermined formula or contribution rate. The situations in which a cause of

action might arise most likely include failure to pay promised benefits, a dispute over the amount of benefits, or allegations of abuse of promised funds. Each of these causes of action neatly fits under ERISA's multi-part enforcement test. 29 U.S.C. § 1132(a) (2003). In contrast, most health benefit disputes center on whether requested or received treatment was "medically necessary," a concept not defined by ERISA or subject to any ERISA standards. Thus, although health plan payment procedures constitute plan administration, accountability for the quality of medical judgment historically has been a matter of state law.

The legislative history also confirms Congress' focus on pensions. The Conference Report to ERISA opens by stating that "[t]he committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (HR 2) *to provide for pension reform*, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows: . . ." H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 1 (1974) (emphasis added). The floor statement of Rep. Perkins, a sponsor of the bill, stated ". . . to summarize what is being done today let me state – after years of study and investigation, hearings and debate, after endless hours of work, *pension reform legislation* of an historic character is almost complete." 120 Cong. Rec. 29,192 (1974) (statement of Rep. Perkins) (emphasis added).

As previously noted, the Senate debate contains similar statements. Senator Williams, one of the bill sponsors, explained that ERISA was ". . . the outgrowth of a 3-year in-depth study of the *private pension system* . . ." 120 Cong. Rec. 29,928 (1974) (statement of Sen. Williams)

(emphasis added). Further, Senator Javits, the lead sponsor of the Senate bill highlighted that ". . . [f]or *the pension reform bill* is the greatest development in the life of the American worker since social security. For the first time in our history most workers will be able truly to retire at retirement age and to live decently on their Social Security, and private pensions." 120 Cong. Rec. 29,933 (1974) (statement of Sen. Javits) (emphasis added). In other words, Senators and Representatives repeatedly referred to ERISA as a *pension* reform bill – to the exclusion of a health care reform bill or even a general employee benefits reform bill.

In fact, other than the definition of an employee welfare benefit plan, at the time of enactment, the statute and legislative history were effectively silent on regulation of health care. *See* 29 U.S.C. § 1002(1) (2003) (ERISA's definition of a welfare benefit plan). As will be seen, Congress intended ERISA to focus on the private pension system while other legislation would deal with health care reform. The enactment of ERISA should not be viewed in a legislative vacuum – but in the context of surrounding legislative activity.

III.

CONGRESS INTENDED TO REGULATE HEALTH CARE THROUGH LEGISLATION OTHER THAN ERISA.

The legislative history of ERISA is almost completely silent on Congress' intent with respect to health care regulation and particularly on issues related to medical treatment decisions, including accountability and liability for harm arising from such decisions. In large part this was due to the fact that Congress intended to regulate

health care through other legislation. And in the case of the Health Maintenance Organization Act of 1973 ("HMO Act"), enacted during the same Congress, it did so. Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified at 42 U.S.C. § 300e (2003)).

The managed care industry was in its infancy in the early 1970s. Accordingly, there was no suggestion that Congress should have considered the shield being asserted to preempt state-based relief for HMO-related actions today. State-based relief issues largely developed over the last decade or so through court-made decisions. *See e.g., Morreim, E.H., Special Issues in ERISA,* HOLDING HEALTH CARE ACCOUNTABLE at 268, n. 46 (Oxford Univ. Press (2001)) (listing roughly 33 federal and state cases); *see also* Zaremski, *Liability of Managed Care Organizations*, LEGAL MEDICINE Ch. 36 (6th Ed. (2004)). Employers generally contracted with health insurance companies that paid on a retrospective basis for covered care. State-licensed health care providers provided treatment under state standards of medical care. *See, e.g., Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

The HMO Act was enacted to provide federal support for the development of HMOs. This law contains a series of provisions which define HMOs and their elements – including covered benefits, assumption of risk, accessibility of services, health care personnel, and consumer role – authorize funding for their development, and create a Commission on Quality Health Care Assurance. 42 U.S.C. § 300e et seq. (2003). The main legislative history for the HMO Act is contained in the Senate Report by the Committee on Labor and Public Welfare. S. Rep. No. 129, 93rd Cong., 1st Sess. (1973). The report contains a section on "Preemption of State Law." *Id.* at 26-27. Nowhere is there

any discussion of federalizing medical or mixed eligibility and treatment decisions made by HMOs comparable to the cases at hand. In the context of its discussion of establishing a Commission on Quality Health Care Assurance, the Committee stated, "[i]t is not the intent of the Committee that the Commission engage in the setting of standards for, or the regulation of, the practice of medicine." *Id.* at 43. The Committee also emphasized that there must be a development of local mechanisms for monitoring and improving the quality of health care services, both in and out of health care assurance systems since local disease patterns and treatment methodologies differ. *Id.* Additionally, the report states, again in connection with a commission on quality health care, that states should be given the opportunity to develop health care standards. *Id.* at 46. One of the reasons was that experience in the medical field indicated that the closer the responsibility for standards development and health care regulation is to the actual provider of care, the more likely the provider is to become involved in the development and setting of standards. The Committee concluded in this regard by saying, "[t]he concept of permitting the state [agencies] to develop their own standards and to enforce them . . . is in keeping with the overall philosophy of the Committee." *Id.*

The HMO Act did not, and did not intend to, federalize standards of medical care or the practice of medicine – the foundation of which is to make medical decisions. Congress has not undertaken passage of any legislation since that time which would vary from the Senate report.

IV.

THERE IS NO LEGISLATIVE HISTORY IN ERISA OR THE HMO ACT THAT CONGRESS INTENDED TO PREEMPT STATE HEALTH CARE REGULATION OR MEDICAL MALPRACTICE LAWS.

There is no legislative history for ERISA, the HMO Act, or any other legislation that provides guidance to suggest, as Petitioners seem to do in their briefs, that Congress intended to shield health benefit plans or their intermediaries from consequences arising from decisions made by those administering the plans affecting the medical care and treatment provided plan participants and beneficiaries (including under the guise of making payments for care or of a plan benefit determination). Those seeking reversal of the court's decisions below seek to stake claim to the position that our silence meant we wanted such a shield to arise in 1974. We failed to speak in 1974 because it was never our intent to have ERISA apply to issues as now before this Court.

As the Court has held, "[t]he question whether a certain state action is pre-empted by federal law is one of congressional intent" and on the ". . . assumption that the historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress." *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45, 107 S.Ct. 1549, 1552, 95 L.Ed. 2d 39, 46 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137-38, 111 S.Ct. 478, 482-83, 112 L.Ed. 2d 474, 482-83 (1990); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 1676, 131 L.Ed.2d 695, 704-705 (1995) (citing previous Court rulings).

There is limited Congressional legislative history on the intent of ERISA's preemption provisions. Legislative debate was focused on the bill's funding and fiduciary requirements. The House and Senate-passed versions of ERISA only preempted state laws that covered subjects regulated by ERISA. Subcomm. on Labor of Comm. on Labor and Public Welfare, *Legislative History of ERISA*, 94th Cong., 2d Sess. 5282-84 (1977) [hereinafter *Legislative History of ERISA*]. The preemption language was broadened in conference largely due to concerns about state efforts to prevent the expansion of pre-paid legal service plans that were a perceived threat to the legal profession. Rand E. Rosenblatt, Sylvia A. Law & Sara Rosenbaum, LAW AND THE AMERICAN HEALTH CARE SYSTEM 159-177 (Foundation Press 1997). There is no evidence in the legislative history that Congress intended to preempt traditional health care regulation, medical malpractice, or similar laws.

Instead, Congress' focus was on eliminating the threat of state laws that conflicted with the substantive provisions of ERISA regulation. During House floor debate on ERISA, Representative Dent (D-PA), one of the lead House sponsors noted: "With preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent state and local regulation." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent). Senator Williams echoed this explanation in the Senate. He noted that ERISA's preemption provisions are intended to ". . . eliminat[e] the threat of conflicting or inconsistent state and local regulation of employee benefit plans." 120 Cong. Rec. 29,931 (1974) (statement of Sen. Williams). In the summary of differences between the House and Senate versions of the pension reform bill, the

staff comment recommended that ". . . the conferees may want to adopt the rules of the Senate bill, but not allow suit under Title I to be brought in state court. (Suit brought in state court could be based on breach of contract, but suit could be removed, by either party, to federal court in actions involving an interpretation of this Act.)" *Legislative History of ERISA* 5276. Staff reiterated this recommended interpretation in the section on preemption. *Id.* at 5284. The legislative history demonstrates that Congress intended to create certain new federal rights exclusively subject to federal court. However, Congress expected existing contract rights to remain subject to state jurisprudence. **Tort actions were not even mentioned**.

Next, we do not see a material difference between HMOs and physicians where state laws regulating medical judgment quality are concerned. In the case of medical necessity decisions, HMO and physician conduct are identical, differing only in their point in time. They are comparable individuals and entities when making medical treatment decisions, just in different places in line. Petitioners seek to create confusion by arguing that there is no distinction between federal acts of plan administration and the medical judgments that indirectly affect plan administration. Let us show, by way of analogy, why there is, indeed, a distinction – and a critical one. When a pension plan contracts with an investment manager, the manager clearly is still subject to federal and state securities ethics law since ERISA did not preempt federal or state securities law. But, when a pension or health plan contracts with a lawyer or accountant, does ERISA preemption exempt them from state professional liability laws since ERISA section 514(b), the savings clause, does not specifically reference them? *See* 29 U.S.C. § 1144(b) (2003). In fact, during Senate debate on ERISA, Senator Javits

assured Senator Taft (R-OH) that ERISA's preemption provision was not intended to preempt state bar associations from enforcing ethical rules or disciplining members. 120 Cong. Rec. 29,949 (1974) (statement of Sen. Javits). If the Court holds that state malpractice laws do not apply to negligent acts by HMOs simply because they do business with an ERISA plan, then a wide range of other actors also must be exempt. Surely, this is not what the framers of ERISA intended.

Consistent with this interpretation, the Court in *Pegram* rejected reading a malpractice cause of action into ERISA and assumed that state malpractice law continues to govern medical judgment. Medical treatment decision-making and improper processing of benefit claims are different acts and concepts with some overlap as noted in *Pegram*. Having closed the federal door, it is inconceivable that the Court could also close the state door.

V.

THE CONGRESSIONAL DEBATE OVER THE PATIENTS' BILL OF RIGHTS AND SIMILAR LEGISLATION DEMONSTRATES CONGRESS' INTENT TO RETAIN STATE HEALTH CARE REGULATION AND PROVIDE MEANINGFUL STANDARDS AND REMEDIES FOR MEDICAL TREATMENT DECISIONS.

A. Legislative Efforts

In recent years, Congress has devoted extensive legislative activity toward remedying weaknesses in the current health insurance system by seeking to enact a "Patients' Bill of Rights," but an effective measure has yet to be signed into law. Patients' Bill of Rights legislation has included reforms addressed both to the types and form

of benefits that insurers must cover and for redress of wrongful denials of benefits. We note in particular Aetna's assertion that in recent years Congress has adhered to the principle that any damages remedy for eligibility determinations under an ERISA plan should be exclusively *federal* (Br. at 42, n. 23) (emphasis in original text). This is absolutely wrong. Let us make the record of our actions clear.

Since the failure of the 103rd Congress to pass President Clinton's proposed legislation to provide health care for all Americans, there has been considerable effort by Congress to develop minimum standards for health insurers, including appropriate remedies for wrongful injuries suffered by patients, i.e., a "Patients' Bill of Rights." [Legislation also had been introduced to overturn the Court's decision in *Pilot Life*, but was not enacted.] H.R. 1602, 102nd Cong., 1st Sess. (1991); H.R. 1881, 103rd Cong., 1st Sess. (1993). In 1995, the President established a national Advisory Commission on Consumer Rights and Quality in Health Care. The Commission reported its recommendations in 1997, and they were quickly introduced in the House by Congressman Dingell as H.R. 3605 with 193 co-sponsors and in the Senate by Senator Thomas Daschle (D-SD) as S. 1890 with 31 cosponsors. H.R. 3605, 105th Cong., 1st Sess. (1997); S. 1890, 105th Cong., 1st Sess. (1997). These bills were jointly known as the "Patients' Bill of Rights."

Concurrently, the "Patient Access to Responsible Care Act" (H.R. 1415), sponsored by Congressman Charlie Norwood (R-GA), was being considered in the House. This legislation addressed many of the same issues as the Patients' Bill of Rights and was cosponsored, bipartisanly, by 234 members of the House.

Congress was well aware of the confusion in the courts on the issue of state laws and liability under ERISA, and both H.R. 1415 (Sec. 4) and H.R. 3605/ S.1890 (Sec. 302) clarified that causes of action arising out of a health insurer's discretionary medical decision should be considered in state courts. Both bills made clear that ERISA did not preempt state causes of action. No action was taken in the 105th Congress.

During the 106th Congress both the House and Senate passed patient protection bills. The Senate's version (S.1344 sponsored by Senator Trent Lott (R-MS)) was less comprehensive and did not include a provision on the liability of health insurers. S.1344, 106th Cong., 1st Sess. (1999). The bill passed the Senate by a vote of 53-47. The House bill, H.R. 2723, introduced by Reps. Norwood and Dingell, was very similar to H.R. 1415 and H.R. 3605 from the 105th Congress. The legislation provided a detailed set of patient care standards for health insurers, including those contracting with employers, and contained remedies. On October 7, 1999, the bill passed the House by a vote of 275-151. The bill, in Section 302, provided that ERISA would *not* preempt any cause of action under state law to recover damages "resulting from personal injury or for wrongful death in connection with . . . medical services rendered by such person to or for a group health plan" or that arose "out of the arrangement by such person for the provision of . . . medical services." H.R. 2723, 106th Cong., 1st Sess. § 302 (1999). Employers were exempted from this section, except if such employer exercised "***discretionary*** authority to make a ***decision*** on a claim for benefits covered under the plan" and "the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death" *Id.* (emphasis

added). Two other amendments that were considered on the floor included alternative provisions to the remedies for patients in H.R. 2723. All but nine members of the House present and voting that day voted for a provision that would hold health insurers liable for making a medical treatment decision.

The House-Senate Conference Committee was not able to reconcile differences during the 106th Congress. However, it is important to note that in the second session of the 106th Congress, the Senate did, for the first time, pass language that held insurers liable for their discretionary decisions. The amendment by Senator Don Nickles (R-OK), S. Amdt. 3694 to H.R. 4577, passed by a vote of 51-47 on June 29, 2000.

The same scenario repeated itself in the 107th Congress. In this Congress, numerous patient protection bills were introduced, and two main bills passed, S. 1052 and H.R. 2563. S. 1052 was introduced by Senators John McCain (R-AZ), John Edwards (D-NC), and Edward Kennedy (D-MA). On June 29, 2001, S. 1052 was passed in the Senate by a vote of 59-36. Section 402 of the bill provided for the availability of civil remedies and *precluded* preemption of any state cause of action predicated upon the failure to "exercise ordinary care in making a ***decision*** regarding whether an item or service is covered under the terms and conditions of a plan or coverage" and "such failure was a proximate cause of personal injury to, or the death of, the participant or beneficiary." S. 1052, 107th Cong., 1st Sess. § 402 (2001) (emphasis added). Employers were exempted unless they participated in the decision to deny a benefit causing injury. *Id.*

H.R. 2563 was introduced by Reps. Greg Ganske (R-IA) and John D. Dingell and passed the House by a vote of 226-203 on August 2, 2001. While HR 2563 contained many of the same provisions as S. 1052, S. 1052 would have permitted state law causes of action involving medically reviewable decisions and would have expanded federal causes of action for benefit denials not based upon medical decisions. S. 1052 § 402. H.R. 2563 created a federal cause of action that could be heard in state court and subject to state law procedural rules. H.R. 2563, 107th Cong., 1st Sess. § 402 (2001). S. 1052 permitted non-economic damages to be determined by state courts under state law, and H.R. 2563 only permitted state law on damages up to a federally established cap. S. 1052 § 402, H.R. 2563 § 402. Both bills shielded employers and ERISA plans from expanded liability unless the employer or plan participated in the decision-making process. S. 1052 § 402, H.R. 2563 § 402. However, an impasse arose over whether federal limits should be imposed, not whether state law should govern accountability.

Patients' Bill of Rights legislation was again introduced in the 108th Congress: H.R. 596 and H.R. 597 by Congressman Norwood, S. 10 by Senator Daschle and S. 1945 by Senators McCain, Edwards and Kennedy. However, the lack of resolution over federal limits on state damages and the emergence of consensus on the need for Medicare coverage of prescription drugs have taken center stage over Patients' bill of rights legislation. Further, members of Congress were well aware of the Court's decision in *Pegram* and many, ourselves included, were optimistic that its findings and holding would be carried through and expanded upon by the courts.

B. Congressional Intent Cannot be Derived from a Preemption Analysis

As a critical side-note to our discussion here, we must take issue with that which is put forth in the brief for the United States. That brief claims: "'Complete preemption' reflects a Congressional intent for Section 502(a) to provide the exclusive remedies for claims that fall within the scope of that section." (U.S. Br. at 7). The government then states: "But certain statutes so completely occupy an area Congress has chosen to regulate exclusively as federal law, with a federal cause of action, '. . . that any civil complaint raising this select group of claims is necessarily federal in character,'" (citing to *Metropolitan Life v. Taylor*, 481 U.S. 58, 63-64 (1987)) (U.S. Br. at 10), that *Pilot Life* should be interpreted to reflect our rejection of remedies under state law [such as is at issue in the cases at bar] (Br. at 11), and that somehow we have clearly manifested our intent to have ERISA preempt state tort remedies for making medical decisions from which harm is claimed to have arisen. These claims do not pass muster, particularly in light of the legislative histories examined herein.

The preceding pages make clear that we never intended ERISA to preempt state-based remedies for harm resulting from those making medical decisions based upon discretionary judgment that do not meet medical standards of care. In other words, **we have never intended to preempt a state-based scheme for resolving medical negligence claims**. We recognize the sanctity of the states to regulate health care and have never clearly expressed a contrary intent by passing ERISA or other legislation. Medical decisions of the type at issue here were never even on our "radar screen" when we drafted and passed ERISA.

While our emphasis in this brief is to assist this Court with what we know best, our legislative efforts, we are compelled to reference the fact patterns in *Pilot Life* and in *Taylor* and offer an observation about analogizing them to the fact patterns in the instant cases. We note both of the cases pertained to disability benefits for back injuries. In both cases, following the injuries, disability benefits were paid, then terminated (in *Pilot Life*, benefits were also reinstated, then terminated). The lynchpin in these two cases was that *payments* were made; not that medical care was requested prospectively as being medically necessary, as in the instant two cases. To us, this prospective denial of a medical benefit is not denying payment for disability benefits (as this Court was confronted with in *Pilot Life* and *Taylor*). Thus, extrapolation of the Court's analysis of our intent in crafting ERISA using the fact patterns in those two cases would be inappropriate for the instant matters. Indeed, a difference does exist between an HMO entity providing care and treatment in this day and age of healthcare delivery and traditional insurers of days past making post-treatment coverage decisions to pay or not to pay for treatment already given. See U.S. Br. at 15. If treatment was already given and the only issue was payment, then the medical decision-making process is never implicated; only payment for care given in the past.

To put it another way, Ms. Calad needed to be hospitalized for more than one day; a decision was made to deny this request; Ms. Calad, in other words, had *not* already stayed hospitalized for more than for what her pre-certification allowed and then asked to be reimbursed for the expense of this additional time. If that were her issue, then *Pilot Life* and *Taylor* might be useful precedent. So, too, with Mr. Davila, if he had already received Vioxx but

Aetna would not pay for it following a request for payment, then payment, and solely payment, would replace any medical decision-making prospectively made as the central fact to be considered by this Court. To this extent, then, we would find the government's characterization of the Davila and Calad fact patterns to be in error. U.S. Br. at 14, 15 ("Specifically, Davila's claim requires a showing that Davila was entitled to payment for Vioxx. . . ." and, "If Calad did not have a legal right under her ERISA plan to payment. . . .").

Parenthetically, this Court in *Pilot Life* referenced our observations of the civil enforcement provisions in Sec. 502(a) of ERISA in the Conference Report (on ERISA) for causes of action arising in federal courts in similar fashion to those (suits) brought pursuant to Section 301 of the Labor-Management Relations Act of 1947 ("LMRA") (481 U.S. at 55). The Court went on to state that, when we enacted ERISA, we were aware of the preemptive force of LMRA's Section 301 for violations of contracts between an employer and a labor organization, 301's preemption of any 'state-law claim whose resolution is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract' [citation omitted], and ERISA's goal of bringing uniformity of [legal] decision which it was designed to foster. *Id.* The type of decisions based on discretionary judgment on a forward-looking basis made by petitioners in the cases at bar are neither predicated on words of a contract, analysis of terms of an agreement nor on processing a claim for care already rendered and therefore not based on a claim for inappropriately processing a claim for care given. For these reasons, and for purposes here, any linkage of words we put forth in the Conference Report on ERISA regarding

civil enforcement provisions of Section 502(a) and LMRA's Section 301 should not be persuasive in any judicial analysis.

C. Legislative Efforts Are a Beacon for the Court

The importance of the legislative action regarding the Patients' Bill of Rights is clear. On several occasions both chambers of Congress have passed patient protection legislation that would provide for state court venue and remedies for harm arising from discretionary decision-making made by entities such as before the Court here. As late as 2003 (*see* H.R. 5, § 13 at 26), there remains as well a recognition that those health insuring entities should be held liable when they make decisions as to the medical necessity of care and treatment provided beneficiaries of those entities.

There is another important aspect to what, in general, Congress has done over the last four years concerning remedies available to plan beneficiaries for their care and treatment arising out of decisions based on discretionary judgments. There should be but one venue to adjudicate harm arising from medical treatment decisions – and it should be the states and territories. To adopt a position by Aetna and Cigna in these cases would mean that, even though those entities administer health benefits and make the same decisions as healthcare providers found in doctors' offices or in hospital corridors – whether mixed eligibility and treatment or not – such entities would be subject to the federal courts to adjudicate any harm arising from their decisions, while doctors and hospitals would be subject to state courts for making precisely the same decisions. We do not countenance such duplication of legal resources, have never envisioned this through our

legislative efforts in this arena, and are certain neither would this Court. Again, as states have been charged with policing health care, i.e., regulating the medical decision-making process, so, too, states should remain the place of adjudication for claims from harm arising therefrom. Such judgments on treatment do not implicate ERISA's focus on uniform administration since these are not primarily decisions about proper processing of benefit claims, but decisions about appropriate delivery of medical care.

Furthermore, the suggestion has been advanced on behalf of petitioners that our branch of government should be the one to make more certain that which we passed with our ERISA legislation rather than for this Court to undertake it. While many occasions have existed in this Court's jurisprudence where such legislative action was necessary, the facts giving rise to the instant cases do not call for us to rethink what we did in 1974. We say this for two reasons. First, the language of our act is not a result of having consciously dealt in any way with accountability for discretionary decision-making as to medically necessary care and treatment provided participants and beneficiaries of health plans. Nor is it the result of any prior knowledge on our part of what HMOs did back in the early 1970s. *A fortiori*, we think it inappropriate for the Court to suggest that we make revisions to ERISA to language that never addressed the issues here in the first instance.

Second, our efforts to make clear what ERISA should preempt or not preempt in the area of medical decision-making was occasioned by the development of case law over the last decade, providing interpretations of ERISA, e.g. quality versus quantity of care, treatment versus administrative decisions, and even the "mixed eligibility/treatment" decision. Because the issues raised in these

cases arise from court-made interpretations of language we never enacted nor in any sense intended to enact, it appears more appropriate for this Court to take the lead in crafting a clear and distinct standard to be applied by lower courts to fact patterns such as the two put forth in these cases. It is easier for this Court to clarify its previous interpretations of preemption by ERISA, than for Congress to override employer and industry opposition and restore what we never intended to take away in the first instance.

VI.

CONGRESSIONAL REPORTS DEMONSTRATE THAT STATE LIABILITY DOES NOT SIGNIFICANTLY AFFECT EMPLOYER OR INSURER HEALTH CARE COSTS

Employers establish employee benefit plans because their employees value them and they serve the employer's economic interests, as evidenced by over $200 billion in annual tax deductions. U.S. Joint Committee on Taxation, *Estimates Of Federal Tax Expenditures For Fiscal Years 2004-2008*, Rept. JCS-8-03, 108th Cong., 1st Sess. (2003). Almost all large employers maintain a range of employee benefit plans, and small employers offer some benefits as soon as they are profitable enough to do so. Linked to this are the studies which have found that approximately 1% of the actual victims of malpractice bring a judicial action and less than 50% of plaintiffs are successful. See e.g., A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Effects Due to Negligence*, NEW ENGLAND JOURNAL OF MEDICINE, vol. 325, no. 4, July 25, 1991. Moreover, the Congressional Budget Office estimate on Patients' Bill of Rights legislation found that

the effect of its liability provisions on health care costs would be less than 1%. Congressional Budget Office Cost Estimate on S. 1052, the Bipartisan Patients' Bill of Rights Act, July 20, 2001.

Further, recent reports by both the Congressional Budget Office (CBO) and General Accounting Office (GAO) have refuted employer and insurer claims of increased costs from medical decision-making, accountability and liability. The CBO has found that malpractice costs account for less than 2% of health care spending and claims that limiting tort liability will reduce the practice of "defensive medicine" are weak or inconclusive. *Limiting Tort Liability for Medical Malpractice*, ECONOMIC AND BUDGET ISSUE BRIEF, Congressional Budget Office at 1, January 8, 2004. The CBO found that

> . . . if malpractice is defined clearly but too broadly or if awards tend to be too high, doctors may engage in defensive medicine, inefficiently restrict their practices, or retire. Conversely, if doctors face less than the full costs of their negligence – because they are insulated by liability insurance or because malpractice is unrecognized or under-compensated – they may have too little incentive to avoid risky practices. For all of those reasons, it is not clear whether trying to control malpractice by means of liability improves economic efficiency or reduces it.

Id. at 2. Similarly, the GAO released two reports examining issues related to medical malpractice and health care costs and found that claims that liability costs affect access to health care were "limited" and "cannot be generalized". *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, US General Accounting Office at 1, GAO-03-836, August 2003; *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, US General Accounting Office, GAO-03-702, June 27, 2003.

Consequently, the fears of employers and their intermediaries that state liability will chill employee benefit plans and ERISA's scheme of uniformity are simply unfounded. There are many ways in which ERISA plans and providers adhere to state standards, including state statutes of limitations, mandated benefit requirements for insurance, and enforcement of judgments. As always, employers and service providers will successfully adjust. In contrast, without some state protections, hundreds of millions of workers, retirees, and their families would have no source of protection. At a time when access to health care is more valuable than ever and federal solutions more elusive than ever, the states are critical protectors of our fraying health care system.

CONCLUSION

Justice O'Connor was exactly right when she wrote for the Court in *Pilot Life*: "The question whether a certain state action is pre-empted by federal law is one of congressional intent. '***The purpose of Congress is the ultimate touchstone.***'" 481 U.S. at 45 (citations omitted) (emphasis added). As *Amici Curiae,* we hope this brief has shed light on that touchstone: we never intended ERISA to preempt state-based tort remedies grounded in malpractice jurisprudence brought against managed care entities, i.e., HMOs, based on their personnel denying on a prospective basis a request for care and treatment as not medically

necessary where the denial results from medical decision-making based upon the exercise of discretionary judgment.

For the foregoing reasons, we respectfully request that the decisions of the Fifth Circuit be affirmed.

Respectfully submitted,

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